What is "UPCODING" or "UPCHARGING?"

Medical providers who bill Medicare, Medicaid, and other Government programs use a standardized system of numerical codes for patient services. In this way, insurers and the Government do not have to decipher what services were provided from myriad records or from thousands of different types of coding or billing systems.

You have probably seen many of the more common codes on an ordinary billing statement from your own physician. Of course, in a hospital setting or other specialized area of medicine, there are many more applicable codes than those that appear pre-printed on the bill for your outpatient visit to the family doctor. **Misuse of these standardized codes to obtain more money than is allowed by law is commonly termed "UPCODING" or "UPCHARGING."**

Each Medicare billing code is tied to a particular group of services and will eventually result in a reimbursement to the physician or other provider (hospital, psychologist, chiropractor, etc.) based upon the code entered by the provider. **Providers have financial incentives to "upcode" – or increase the bill by exaggerating or even falsely representing what medical conditions were present and what services were provided.**

<u>UPCODING EXAMPLE</u> – when a 2-minute visit for diagnosis and treatment of an upper respiratory condition (i.e., a cold without complications) is "upcharged" from a very low reimbursement rate code by intentionally using codes for a more serious ailment. Thus, the "URI" or "upper respiratory infection" diagnosis is altered to indicate that the patient was suffering from a more severe bronchitis and sinus infection, with some breathing impairment requiring nebulizer treatment, and the patient required a full 1-hour office visit. In either case, whether the additional services billed were not even provided or if provided but not medically needed, a fraudulent "upcharge" occurs.

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